STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
155519		B. WING		08/22/2011			
		II.		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	₹	l l	16TH ST			
GENTLE	CARE OF VINCEN	NES	VINCENNES, IN47591				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	· ·	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0000							
	A Life Cafety C	ada Dagartification	K0000	This plan of correction is			
	=	ode Recertification	Koooo	submitted to serve as allega	tions		
		isure Survey was		of compliance. Preparation			
	· ·	he Indiana State		and/or execution of this plan			
	Department of			corrections does not constitu	I		
	accordance wit	th 42 CFR 483.70(a).		admission or agreement by provider of the allegations or			
				conclusions set forth in the			
	Survey Date: 0	08/22/11		statements of deficiencies.			
	Facility Numbe	r: 000357					
	Provider Numb	er: 155519					
	AIM Number: 100291370						
	,						
	Surveyor: Lex Brashear, Life Safety						
	Code Specialist						
	- Code Specians						
	At this Life Safe	ety Code survey,					
	Gentlecare of \	•					
	found not in co						
	-	for Participation in					
	Medicare/Medi						
	-	O(a), Life Safety					
	from Fire and t	the 2000 edition of					
	the National Fi	re Protection					
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410						
	IAC 16.2.						
	This one story	facility with a					
	=	determined to be of					
		onstruction and was					
	.ypc v (000) C	onstruction and was					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BC7E21

Facility ID:

000357

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155519			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLETS  A. BUILDING  B. WING 01 08/22/201		ETED			
NAME OF PROVIDER OR SUPPLIER  GENTLECARE OF VINCENNES			STREET ADDRESS, CITY, STATE, ZIP CODE  1202 S 16TH ST  VINCENNES, IN47591					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACT) CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ON SHOULD BE COMPLETION THE APPROPRIATE		
	a fire alarm system detection in the spaces open to facility has a call had a census of this survey.  Quality Review by I Code Specialist-Med  The facility was compliance with aforementioned.	the corridors. The apacity of 60 and f 48 at the time of  Robert Booher, Life Safety dical Surveyor on 08/23/11.  Is found not in h the						
K0029 SS=E	fire-rated doors) of extinguishing system and/or 19.3.5.4 prowing when the approve extinguishing system are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  Based on observant	em option is used, the areas on other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches the door are permitted.	K00	29	Corrective action for resident found to have been affected:	-	08/31/2011	
	interview, the f ensure 1 of 10 room doors, su door, was equi	hazardous area ch as a kitchen			residents were found to have been affected by this practice Identification of Residents to having the potential to be affected: Per survey findings	<b>.</b>		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155519			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 01	(X3) DATE SURVE COMPLETED 08/22/2011	ΕY	
NAME OF PROVIDER OR SUPPLIER			B. WING OO/22/2011  STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST				
GENTLECARE OF VINCENNES				NNES, IN47591			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) MPLETION DATE	
	device on the depractice could a residents, as we visitors while in area. Findings include  Based on obsert 08/22/11 at 13 tour of the facit Maintenance Sukitchen door to area was provided closing device, did not close contested several to one inch gap be	the front lobby  de:  Evation on  1:10 a.m. during a  lity with  upervisor, the  the front lobby  ded with a self  however, the door  completely when  times. There was a  etween the door  when closed. This  ged by the  upervisor at the		residents, staff and visitors win the front lobby area have potential to be affected. The Maintenance Supervisor repthe self closing device on the kitchen door to the front lobb Measures or systemic chang prevent recurrence: The kitch door (as well as all other hazardous area room doors be inspected monthly by the Maintenance Superior. The results of the inspections will recorded and presented to the Administrator for review. Corrective action monitored: Administrator and the Maintenance Supervisor will monitor compliance with this of Corrections and report to facility's Continuous Quality Improvement Committee. To Continuous Quality Improve Committee meets monthly with findings reported to the quarterly Quality Assurance Committee.	the ellaced elloy. ges to chen ) will I be ne The s Plan the he ment		
K0062 SS=E	continuously main condition and are periodically. 19. 25, 9.7.5 Based on obser interview, the f		K0062	Corrective action for residen found to have been affected residents were found to have been affected by this practic	: No	/31/2011	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	i i		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
	155519		B. WIN	NG		08/22/2	011
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE		
					16TH ST		
GENTLECARE OF VINCENNES				VINCE	NNES, IN47591		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		cility were free of			Identification of residents have the potential to be affected:		
	paint. NFPA 10	01 Section 9.7.5			survey findings; all residents		
	refers to NFPA	25, Standard for			and visitors while in Hall 3 or		
	the Inspection,	Testing, and			2 and front lobby have the		
	Maintenance o	f Water-Based Fire			potential to be affected. Fac	ility	
	Protection Syst	ems. NFPA 25,			contacted Tri-State Fire Protection to schedule		
	· ·	es sprinklers to be			replacement of sprinkler hea	ds.	
	· ·	Any sprinkler shall			The sprinkler heads in Hall 3		
	<u> </u>	at is painted. This			storage room and Hall 2 Billi	ng	
	· ·	ice could affect any			Office were replaced.		
	· ·	•			(Attachment A) Measures or		
	of the 48 residents, as well as staff and visitors while in the Hall 3 corridor, or Hall 2 corridor and front lobby which were part of the			systemic changes to prevent recurrence: The sprinkler heads in Hall 3 storage room and Hall 2 Billing office (as well as all other			
	same smoke compartment.  Findings include:				monthly by the Maintenance Supervisor. Sprinkler heads	with	
					paint on them will be replace		
					The results of the inspection		
					be recorded and presented to the Administrator for review.		
	Based on obse	rvations on					
	08/22/11 at 1	0:20 a.m. and again			Corrective action monitored: Administrator and the	rne	
	at 10:40 a.m. o	during a tour of the			Maintenance Supervisor will		
	facility with the	e Maintenance			monitor compliance with this	Plan	
	Supervisor, the	sprinkler head in			of Correction and report to the	ie	
		age room and the			facility's Continuous Quality		
		in the Hall 2 Billing			Improvement Committee. The Continuous Quality Improver		
	_ ·	rtially covered with			Committee meets monthly w		
	white paint. The				the findings reported to the		
		by the Maintenance			quarterly Quality Assurance		
					Committee.		
	Supervisor at the time of each observation.						
	observation.						
	2.1.10/5)						
	3.1-19(b)						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155519		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/22/2011			
NAME OF PROVIDER OR SUPPLIER  GENTLECARE OF VINCENNES				STREET ADDRESS, CITY, STATE, ZIP CODE  1202 S 16TH ST  VINCENNES, IN47591					
(X4) ID PREFIX TAG K0069 SS=B	(EACH DEFICIEN REGULATORY OR Cooking facilities a with 9.2.3. 19.3	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) are protected in accordance 2.6, NFPA 96	V	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Corrective action for residen		(X5) COMPLETION DATE		
	and observation to ensure 1 of systems was clasemiannually. Edition, Standar Control and Fire Commercial Control and Fire Commercial Control and Fire Commercial Control and Fire Commercial Control and Fire Control and Fire Control device other appurtent cleaned to bare intervals prior of the exhaust systems are metal, it is with powder or the entire exhaust systems are metal, it is with powder or The entire exhaust systems are metal, it is with powder or The entire exhaust systems are metal, it is systems serving cooking operations of the exhaust systems of the exha	NFPA 96, 1998 rd for Ventilation e Protection of ooking Operations, hoods, grease s, fans, ducts, and ances shall be e metal at frequent to surfaces illy contaminated oily sludge. After stem is cleaned to hall not be coated other substance. aust system shall be properly trained, tertified company accordance with fable 8–3.1 requires g moderate volume ions shall be annually. This ce could affect any or visitor in the	K	0069	Corrective action for resident found to have been affected residents were found to have been affected residents were found to have been affected by this practic Identification of residents had the potential to be affected: survey findings; all resident staff or visitors in the vicinity the kitchen have the potential be affected. The maintenant Supervisor contacted Sure (facility's contracted cleaning service) to schedule the clean of the kitchen exhaust system Clean cleaned and inspected kitchen exhaust system. (Attachment B) and schedul next semi-annual cleaning. Measures or systemic change prevent recurrence: The Maintenance Supervisor will review cleaning schedule for kitchen exhaust system mor The Maintenance Supervisor contact Sure Clean (facility's contracted cleaning service) days in advance of required semi-annual kitchen exhaus cleaning to schedule the ser The Maintenance Supervisor report cleaning schedule of kitchen exhaust system to the Administrator. Corrective active monitored: The Administration and the Maintenance Supervisor will monitor compliance with Plan of Correction and report the facility's Continuous Quality Imrovment Committee. To Continuous Quality Imrovment	e e. ving Per s, of all to ce Clean G aning m. ystem ed ges to r will s 30 t vice. r will section tor visor this et to ality he	08/31/2011		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	BC7E21	Facility II	D: 000357 If continuation s	sheet Pa	ge 5 of 6		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155519			LDING	NSTRUCTION  01	(X3) DATE: COMPL 08/22/2	ETED		
NAME OF PROVIDER OR SUPPLIER  GENTLECARE OF VINCENNES			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S 16TH ST VINCENNES, IN47591					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Based on review range inspection Fire Alarm fold 9:00 a.m. with Supervisor presidocumentation kitchen range in cleaned within months. Based 11:30 a.m. dur facility with the Supervisor, the the kitchen range indicated the racility and the next sched in April of 201 confirmed by the Supervisor at the observation, further phone call at 1 Maintenance So with the range vendor, the holes.	w of the kitchen on reports in the er on 08/22/11 at the Maintenance sent, there was no to show the nood had been the past six d on observation at ing a tour of the e Maintenance re was a sticker on age hood which ange hood was tember of 2010 with uled cleaning due 1. This was he Maintenance he time of rthermore, per 1:45 a.m., the upervisor confirmed			Committee meets monthly with findings reported to the quarterly Quality Assurance Committee. ATTACHMENT - Receipt from Tri-State ATTACHMENT B - Receipt Sure-Clean	A		